MONTEFIORE MEDICAL CENTER
The University Hospital for the Albert Einstein College of Medicine
DEPARTMENT OF RADIATION ONCOLOGY
ALBERT EINSTEIN COLLEGE OF MEDICINE OF YESHIVA UNIVERSITY

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October 26, 2004

Avi Einzig, M.D.
Medical Oncology
1695 Eastchester Road, Suite 304
Bronx, NY 10461

RE: CHARLES JARVIS
02390485

Dear Dr. Einzig:

As you know, Charles Jarvis has completed radiation. He is diagnosed as having a T2N3 nasopharynx cancer. He received chemotherapy concomitant with his radiation as per you.

Area Treated	Energy/ Modality	Dose FX (Gy)	Total Dose (Gy)	Dates From/To
Nasopharynx & upper neck via lateral opposed portals	6 MV	2.0	40.0	7/15/04-8/16/04
Upper neck with cord block via lateral opposed portals	6 MV	2.0	10.0	8/17/04-8/24/04
Nasopharynx & upper neck boost via lateral opposed portals with cord block	6 MV	2.0	20.0	8/25/04-9/9/04

(On 9/1/04 the machine malfunctioned, and he only received 0.5 Gy to the right lateral field on that day).

Cumulative dose to tumor and upper: 70.5 Gy.

Area Treated	Energy/ Modality	Dose FX (Gy)	Total Dose (Gy)	Dates From/To
Low anterior neck via AP/PA opposed ports	6 MV	2.0	40.0	7/15/04-8/16/04
Low anterior neck with cord block via AP/PA opposed ports	6 MV	2.0	20.0	8/17/04-8/31/04
Low anterior neck nodal boost via anterior portal with cord block	6 MV	2.0	10.0	9/2/04-9/9/04

Cumulative dose to lower neck gross adenopathy: 70.0 Gy.

(On 9/1/04, the machine malfunctioned; he received no dose to the lower anterior neck on that day).

(The brachial plexus was blocked for the last 10 Gy, so he received at most a dose of 60 Gy).

Area Treated	Energy/ Modality	Dose FX (Gy)	Total Dose (Gy)	Dates From/To
Right post neck boost via direct lateral electron ports	12 MeV electrons	2.0	30.0	8/17/04-9/9/04
Left post neck boost via direct lateral electron port	12 MeV electrons	2.0	30	

Cumulative dose to posterior gross neck adenopathy: 70.0 Gy.

ADDITIONAL COMMENTS
It was not possible to treat Mr. Jarvis with more advanced form of radiation such as IMRT because of his inability to lie still on the table.

RESPONSE TO THERAPY
Mr. Jarvis' adenopathy and nasopharyngeal tumor completely resolved during treatment.

ADDITIONAL COMMENTS
Mr. Jarvis has also received amifostine.

SIDE EFFECTS AND MANAGEMENT
Mr. Jarvis developed mucositis throughout the oral cavity and pharynx. This caused him to have difficulty swallowing, which required placement of a PEG tube and also admittance to the hospital for hydration. He also developed desquamation in the fields externally, which caused him to experience some mild to moderate skin irritation.

DISPOSITION
Mr. Jarvis returned for follow-up yesterday. He is still complaining of sore throat and odynophagia, which requires him to still use his tube, although he does have partial PO intake, especially liquids or soft foods. He was complaining of xerostomia, and feeling weak and dizzy. He states that he has not been able to continue his chemotherapy because of these symptoms.

On examination, he is noted to have hyperpigmentation throughout the external treatment portals. His mucositis in the oral cavity and oropharynx on direct visualization was noted to have healed.

Fiberoptic examination revealed no evidence of tumor. Additionally, the mucosa was noted to be healed with no erythema.

Ms. Jarvis was advised to follow up in two months' time and also to continue to follow with you. I reassured him that he will likely continue to improve over the next several months.

I would like to thank you for allowing us to participate in Mr. Jarvis' care.

Sincerely,

James Butler, M.D.
Department of Radiation Oncology

cc: David Gitler, M.D.
1578 Williamsbridge Road
Bronx, NY 10461

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ALBERT EINSTEIN COLLEGE OF MEDICINE OF YESHIVA UNIVERSITY

JAMES BUTLER, M.D.
Assistant Professor
Residency Program Director
Department of Radiation Oncology

June 22, 2004

Avi Einzig, M.D.
Medical Oncology
1695 Eastchester Road, Suite #304
Bronx, NY 10461

RE: CHARLES JARVIS
02390485

Dear Dr. Einzig:

Thank you for sending your patient, Charles Jarvis, to our department for an opinion regarding radiation. As you know, he is a 46-year-old male who developed epistaxis in April. He was subsequently referred to Dr. Gitler. Dr. Gitler examined him, noted a mass in the nasopharynx, biopsy of which revealed undifferentiated carcinoma. Workup which at the moment includes only head CT, CT of the paranasal sinuses, and chest x-ray does not reveal evidence of disease elsewhere. CAT scan of the neck and PET scan are pending at University Diagnostics for 6/24/04 and 6/25/04. Mr. Jarvis currently is continuing to complain of occasional episodes of epistaxis, sore throat. He is status post placement of a right tympanic membrane tube because of an otitis media secondary presumably to his nasopharyngeal tumor. He also complains of occasional right otalgia. He states he has peripheral neuropathy because of his diabetes.

Past history is notable for insulin-dependent diabetes, hypertension, past history of cerebrovascular accident, and transient ischemic attacks. He is status post sinus surgery for polyps on one occasion two years ago and then again this year. He had a cyst removed in 1993 from tailbone. He denies ever having received radiation or chemotherapy.

His family history is notable for father who had colon cancer. Multiple maternal uncles who had colon cancer. Maternal aunt who had stomach cancer. Maternal uncle who had throat cancer. He states that he smoked half a pack per day of cigarettes from when he was a teenager until about five years ago. He denies alcohol abuse.

PHYSICAL EXAMINATION
General appearance is good. Karnofsky status is 80. He is moderately obese. The lungs are clear. The heart sounds are regular. A left 6 x 4 left level 2 mass is palpable. A right 4 x 3 level 2 mass is palpable. No other adenopathy is appreciated. Examination of the oral cavity and pharynx via direct visualization and palpation does not reveal evidence of disease.

Fiberoptic examination reveals a mass that involves the roof of the nasopharynx and the right side of the nasopharynx, which obliterates the architecture in this area and, of course, obstructs the opening of his eustachian tube. This mass is noted to be fungating and ulcerated.

IMPRESSION
Mr. Jarvis is diagnosed as having T2N3 nasopharyngeal carcinoma. Workup is still in progress. He is noted to have poor dentition with six teeth in poor repair in his lower jaw.

PLANS/RECOMMENDATION
I have explained to Mr. Jarvis that I agree with your recommendation for him to receive radiation and chemotherapy provided, of course, the workup is negative for metastatic disease. I explained the purpose of radiation and chemotherapy will be to eradicate his disease. The risks of radiation include but are not limited to soft tissue necrosis, laryngeal damage, osteoradionecrosis, chances of which can be minimized by adequate dental care prior to commencement of radiation, damaged parotid glands leading to xerostomia, the severity of which can be limited by the use of amifostine during radiation (he was informed that amifostine can cause nausea, vomiting, and hypertension). He was advised that there were no good alternatives to radiation and chemotherapy, as radiation alone is inferior, chemotherapy alone is noncurative, and this disease is not able to be treated with surgery alone. Mr. Jarvis states he understands and agrees with the plan of management. As he came in late yesterday, we were unable to arrange for him to be seen at dental clinic at that time, therefore we will be arranging for this today. We will be arranging simulation after he has visited the dental clinic for possible extractions. If he does require extractions, then we will

not be able to begin radiation for 10 days to two weeks thereafter. I will, of course, coordinate with your office the start of radiation such that you can begin chemotherapy concomitantly.

Sincerely,

James Butler, M.D.
Department of Radiation Oncology

cc: David Gitler, M.D.
1578 Williamsbridge Road
Bronx, NY 10461

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